# APPLICATION FOR APPROVAL OF THE DINING ASSISTANT PROGRAM

State Form
Indiana State Department of Health – Division of Long Term Care

## SECTION A: Training program information

Name of Facility:_____

Street Address:_____

PO BOX #:_____

City:_____State_____

ZIP:_____Phone number:_____Fax number:_____

## SECTION B: Program Director information

Name:_____

Nursing License #:_____ **A copy of the license MUST accompany this application**

***QUALIFICATIONS: PLEASE PROVIDE SPECIFIC DATES & LOCATIONS FOR THE FOLLOWING:***

**NURSING EXPERIENCE:**

**LONG TERM CARE EXPERIENCE:**

**TEACHING EXPERIENCE:**

***A COPY OF THE DINING ASSISTANT OR C.N.A. TRAIN-THE-TRAINER COURSE CERTIFICATE MUST ACCOMPANY THIS APPLICATION***

## SECTION C: Certification of program

I certify that the Dining Assistant Training Program will be conducted in accordance with the Health Facility Criteria adopted, including the program records for ISDH personnel.

_____ _____

Administrator of facility Date

**Mail completed application, along with requested documentation to:**

INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF LONG TERM CARE
2 N. MERIDIAN ST., 4B
INDIANAPOLIS, IN 46204

Please use additional applications for more than one program director. Remember to save a copy of this application for your records.